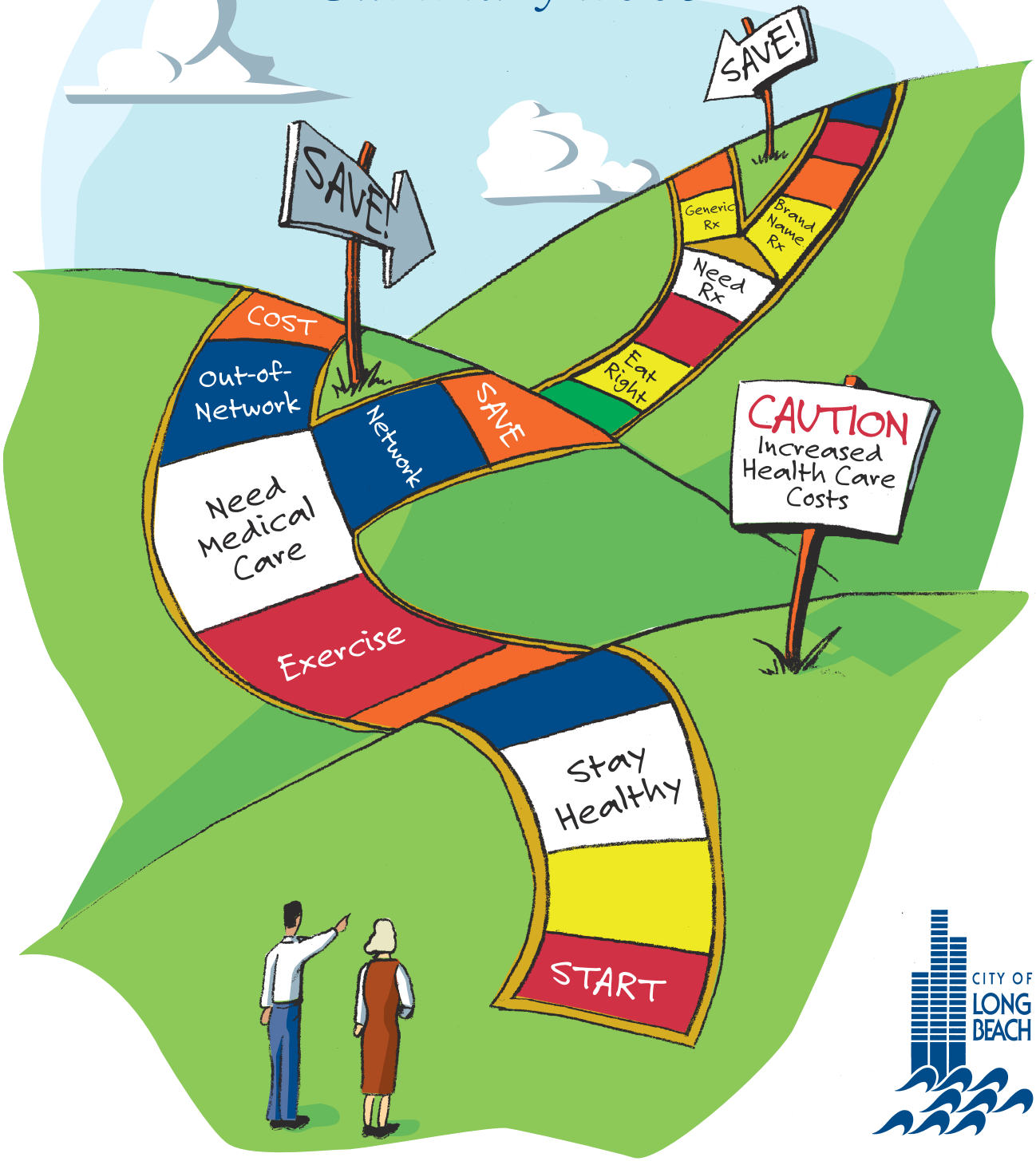
Your Benefits

Your Move

Retiree Benefits Summary 2003



CITY OF LONG BEACH

To City of Long Beach Retirees

Another year has passed and it is once again time to evaluate your personal needs and make new retiree health care benefit decisions for 2003. It's *Your Benefits. Your Move.* Choosing the benefits that are right for you requires care and attention, strategic thinking, and a certain amount of homework. Take the time to read your printed materials. This is your once-a-year opportunity to make your move to the plan that suits you best.

Health Care Costs Continue to Rise

As you may be aware, the subject of health care inflation has reemerged in recent months and still the outlook is grim – double-digit increases with no end in sight. You will continue to receive the same quality retiree health care coverage you have come to expect from the City of Long Beach, but your costs will be higher in 2003. The City remains committed to making sure that its retiree health benefits remain competitive and affordable, but to achieve this goal, all players – the City, retirees, payers, and providers – must work together and find ways to use our plans more efficiently. If you are a retiree not on Medicare, here are some steps you can take that ultimately will help reduce costs:

- Eat healthy, exercise, don't smoke, and get regular check-ups;
- If you need medicine, take it as prescribed by your doctor;
- Use network providers for primary care and referrals;
- Always request generic drugs;
- Use PCS Mail Order;
- Check hospital bills for errors;
- Get a second opinion for non-elective surgeries; and
- Follow precertification procedures for hospitalizations and surgeries.

More POS Providers

Retirees who participate in the Long Beach Choice or Great-West Life Point of Service (POS) Plans will now have access to a more extensive provider network. To find out if a provider is available in your area, please call the City's Human Resources Department.

Open Enrollment

This brochure highlights the key features of the medical plan options offered to you as a City of Long Beach retiree. Please take the time to review your options thoroughly and make your selections carefully. *If you or your spouse will turn 65 at any time during the coming plan year, be sure to factor this into your decision for 2003.* The choices you make during this open enrollment will be effective from **February 1, 2003 through January 31, 2004.**

You are also encouraged to attend the Question and Answer session to be held at the Main Library, Lower Level, from 10:00 a.m. to 12:00 p.m. on Friday, October 11, 2002. If you have questions or need more information, contact Human Resources at (562) 570-6302.

Have a safe and healthy year.

Sincerely,

Deborah R Mills

DEBORAH R. MILLS

Employee Benefits & Services Officer

Comparison of Medical Plan Benefits For Retirees Under Age 65 and Not Eligible for Medicare

This table summarizes benefits for each of the City's medical plans. Note that the Long Beach Choice POS Plan and Great-West Life POS Plan provide the same coverage. However, the cost of coverage varies for each plan. Plan year deductibles are the amount you pay each year (where applicable) before your plan begins paying benefits.

	Long Beach Choice POS & Great-West Life POS	Great-West PPO Value Plan	Great-West PPO High Plan	Great-West PPO Low Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only* **	PacifiCare of California Low Plan *PCP/PMG Approved Care Only* **
Plan Year Deductible	***In-Network:*** $0 ***Out-of-Network:*** $200 individual $400 family	***In-Network:*** $200 individual $400 family ***Out-of-Network:*** Same as In-Network	***In-Network:*** $200 individual $400 family ***Out-of-Network:*** Same as In-Network	***In-Network:*** $300 individual $600 family ***Out-of-Network:*** Same as In-Network	$0	$0
Lifetime Maximum	***In-Network:*** Unlimited ***Out-of-Network:*** $1,000,000	***In-Network:*** Unlimited ***Out-of-Network:*** $1,000,000	***In-Network:*** Unlimited ***Out-of-Network:*** $1,000,000	***In-Network:*** Unlimited ***Out-of-Network:*** $1,000,000	Unlimited	Unlimited
Covered Expense/Out-of-Pocket Limit	***In-Network:*** Not applicable ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $20,000 of covered expenses (i.e., $4,000 of out-of pocket expenses excluding deductibles and copayments) for each covered individual ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $25,000 of covered expenses (i.e., $2,500 of out-of pocket expenses excluding deductibles and copayments) for each covered individual ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $100,000 of covered expenses (i.e., $20,000 of out-of pocket expenses excluding deductibles and copayments) for each covered individual ***Out-of-Network:*** No limit	$1,000 annual copay maximum per individual (limit of three per family)	$1,500 annual copay maximum per individual (limit of three per family)
Hospitalization	***In-Network:*** 100% ***Out-of-Network:*** 50%* up to covered daily maximum of $300 ($150 a day paid maximum)	***In-Network:*** 80%* ***Out-of-Network:*** You pay $500 per confinement, then covered at 60%* up to $300 per day ($180 paid maximum per day)	***In-Network:*** 90%* ***Out-of-Network:*** You pay $200 per confinement, then covered at 70%* up to $300 per day ($210 paid maximum per day)	***In-Network:*** You pay $200 per confinement, then covered at 80%* ***Out-of-Network:*** You pay $500 per confinement, then covered at 60%* up to $300 per day ($180 paid maximum per day)	Semi-private room or ICU with ancillary services covered in full for unlimited days (include SMI benefits mandated by AB88)	Semi-private room or ICU with ancillary services covered after $250 copay per admission plus 20% copayment for unlimited days (include SMI benefits mandated by AB88)
Hospital Preadmission Tests	***In-Network:*** 100% ***Out-of-Network:*** 50%*	***In-Network:*** 100% ***Out-of-Network:*** 100%	***In-Network:*** 100% ***Out-of-Network:*** 100%	***In-Network:*** 100% ***Out-of-Network:*** 100%	100%**	100%**
Inpatient & Outpatient Surgery	***In-Network:*** 100% ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	100%**	100%**
Physician Charges for Hospital Care & Surgery	***In-Network:*** 100% ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	100%**	100%**

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

Comparison of Medical Plan Benefits For Retirees Under Age 65 and Not Eligible for Medicare (cont.)

	Long Beach Choice POS & Great-West Life POS	Great-West PPO Value Plan	Great-West PPO High Plan	Great-West PPO Low Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only* **	PacifiCare of California Low Plan *PCP/PMG Approved Care Only* **
Emergency Room	***In-Network:*** 100% after you pay $50. Payment waived if hospitalization follows. If possible, contact your PCP for instructions. Otherwise, seek treatment at the nearest facility, then contact your PCP within 48 hours to receive highest plan benefits. ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	$50 copayment per visit. Waived if admitted to the hospital.	$50 copayment per visit. Waived if admitted to the hospital.
Physician Office Visits	***In-Network:*** You pay $15 at the time of visit, then covered at 100% ***Out-of-Network:*** 50%*	***In-Network:*** You pay $20 at the time of visit, then covered at 100% ***Out-of-Network:*** 60%*	***In-Network:*** You pay $20 at the time of visit, then covered at 100% ***Out-of-Network:*** 70%*	***In-Network:*** You pay $25 at the time of visit, then covered at 100% ***Out-of-Network:*** 60%*	$10 copay per visit	$20 copay per visit
Outpatient X-ray & Laboratory	***In-Network:*** 100% ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	Covered in full	Covered in full
Maternity Care	***In-Network:*** 100% ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	Covered in full except for certain elective procedures, which are subject to copays.	Covered in full for outpatient visits; covered at 80% after $250 copay per admission for hospitalization. Certain elective procedures subject to various copays.
Birthing Centers	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	100%**	100%**
Adult Physical & Routine Well-Baby Care	***In-Network:*** You pay $15 at the time of visit, then covered at 100%. Women can self refer for one annual OB/GYN visit within their doctor's managed physician group. ***Out-of-Network:*** 50%* up to $250 per year	***In-Network:*** You pay $20 at the time of visit, then covered at 100% up to $250 per year ***Out-of-Network:*** 60%* up to $250 per year	***In-Network:*** You pay $20 at the time of visit, then covered at 100% up to $250 per year ***Out-of-Network:*** 70%* up to $250 per year	***In-Network:*** You pay $25 at the time of visit, then covered at 100% up to $250 per year ***Out-of-Network:*** 60%* up to $250 per year	Covered in full after $10 copayment. (Waived for Well-Baby Care for children under 2) Limited to one exam each calendar year	Covered in full after $20 copayment. (Waived for Well-Baby Care for children under 2) Limited to one exam each calendar year

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

Comparison of Medical Plan Benefits For Retirees Under Age 65 and Not Eligible for Medicare (cont.)

	Long Beach Choice POS & Great-West Life POS	Great-West PPO Value Plan	Great-West PPO High Plan	Great-West PPO Low Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only ** *	PacifiCare of California Low Plan *PCP/PMG Approved Care Only ** *
Prescription Drugs	***In-Network:*** When you use a PCS pharmacy: $5 generic; $15 brand. Mail order services available. ***Out-of-Network:*** When you use a non-PCS pharmacy, you must file a claim form directly with PCS; the benefit amount paid will be reduced.	***In-Network:*** When you use a PCS pharmacy: $5 generic; $15 brand. Mail order services available. ***Out-of-Network:*** When you use a non-PCS pharmacy, you must file a claim form directly with PCS; the benefit amount paid will be reduced.	***In-Network:*** When you use a PCS pharmacy: $5 generic; $15 brand. Mail order services available. ***Out-of-Network:*** When you use a non-PCS pharmacy, you must file a claim form directly with PCS; the benefit amount paid will be reduced.	***In-Network:*** When you use a PCS pharmacy: $5 generic; $15 brand. Mail order services available. ***Out-of-Network:*** When you use a non-PCS pharmacy, you must file a claim form directly with PCS; the benefit amount paid will be reduced.	You pay $5 per generic, $15 per brand; $25 per non-formulary Mail order services available at 2 times the regular copay for 90-day supply	You pay $5 per generic, $15 per brand; $25 per non-formulary Mail order services available at 2 times the regular copay for 90-day supply
Chiropractic Care	***In-Network:*** Self-referral benefit, no PCP approval required. If you use ASHP network chiropractors, plan pays 100% of contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Self-referral benefit, no PCP approval required. If you use non-network chiropractor, plan pays 50% of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year	***In-Network:*** When you use the ASHP chiropractic network, plan pays 100%* of network contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year.	***In-Network:*** When you use the ASHP chiropractic network, plan pays 100%* of network contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year.	***In-Network:*** When you use the ASHP chiropractic network, plan pays 100%* of network contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year.	$10 copayment; 40 visits (combined with acupuncture) per year through ASHP provider	$15 copayment; 20 visits per year through ASHP provider
Acupuncture	***In-Network:*** 50% of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network, plus deductible	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	$10 copayment; 40 visits (combined with chiropractic) per year through ASHP provider	Not covered
Durable Medical Equipment (DME)	***In-Network:*** With approval from your PCP, the plan pays 100% when you rent or purchase DME from a contracted facility ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 70%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	100%**	100%**
Hearing Aids	***In-Network:*** 100% up to $1,000 every 3 years ***Out-of-Network:*** 50%* up to $1,000 every 3 years	***In-Network:*** 80%* up to $1,000 every 3 years ***Out-of-Network:*** 60%* up to $1,000 every 3 years	***In-Network:*** 90%* up to $1,000 every 3 years ***Out-of-Network:*** 70%* up to $1,000 every 3 years	***In-Network:*** 80%* up to $1,000 every 3 years ***Out-of-Network:*** 60%* up to $1,000 every 3 years	100%; limit of one for each ear in a 3-year period** (hearing exam covered in full after $10 copay)	Not covered. (hearing exam covered after a $20 copayment)

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Comparison of Medical Plan Benefits For Retirees Under Age 65 and Not Eligible for Medicare (cont.)

	Long Beach Choice POS & Great-West Life POS	Great-West PPO Value Plan	Great-West PPO High Plan	Great-West PPO Low Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only ***	PacifiCare of California Low Plan *PCP/PMG Approved Care Only ***
Orthotics	***In-Network:*** 100% up to $75 every 3 years ***Out-of-Network:*** 50%* up to $75 every 3 years	***In-Network:*** 80%* up to $75 every 3 years ***Out-of-Network:*** 60%* up to $75 every 3 years	***In-Network:*** 90%* up to $75 every 3 years ***Out-of-Network:*** 70%* up to $75 every 3 years	***In-Network:*** 80%* up to $75 every 3 years ***Out-of-Network:*** 60%* up to $75 every 3 years	Not covered	Not covered
Vision Benefits	***In-Network:*** Examinations covered at 100% if MES network used. Standard frames and lenses covered in full every 24 months if MES network provider used. ***Out-of-Network:*** If non-network provider used, benefits paid according to maximum allowable expense schedule: Ophthalmologic exam–$67.50; optometric exam–$57.50; Frames–$40; Lenses: $45 (single vision), $63 (bifocal), $80 (trifocal) ; Contact lenses–$100 ($250 if required due to special conditions). See plan booklet for complete schedule.	***In-Network:*** Examinations covered at 100% if MES network used. Standard frames and lenses covered in full every 24 months if MES network provider used. ***Out-of-Network:*** If non-network provider used, benefits paid according to maximum allowable expense schedule: Ophthalmologic exam–$67.50; optometric exam–$57.50; Frames–$40; Lenses: $45 (single vision), $63 (bifocal), $80 (trifocal) ; Contact lenses–$100 ($250 if required due to special conditions). See plan booklet for complete schedule.	***In-Network:*** Examinations covered at 100% if MES network used. Standard frames and lenses covered in full every 24 months if MES network provider used. ***Out-of-Network:*** If non-network provider used, benefits paid according to maximum allowable expense schedule: Ophthalmologic exam–$67.50; optometric exam–$57.50; Frames–$40; Lenses: $45 (single vision), $63 (bifocal), $80 (trifocal) ; Contact lenses–$100 ($250 if required due to special conditions). See plan booklet for complete schedule.	***In-Network:*** Examinations covered at 100% if MES network used. Standard frames and lenses covered in full every 24 months if MES network provider used. ***Out-of-Network:*** If non-network provider used, benefits paid according to maximum allowable expense schedule: Ophthalmologic exam–$67.50; optometric exam–$57.50; Frames–$40; Lenses: $45 (single vision), $63 (bifocal), $80 (trifocal) ; Contact lenses–$100 ($250 if required due to special conditions). See plan booklet for complete schedule.	Eye exam covered in full once every 12 months at MES facility. Lenses covered in full if network provider used; $60 frame allowance every 2 years; Covered through Medical Eye Services (MES)	Eye exam covered in full once every 12 months at MES facility. Lenses covered in full if network provider used; $60 frame allowance every 2 years; Covered through Medical Eye Services (MES)
Inpatient Mental Health & Substance Abuse Treatment	***In-Network:*** 100%; 30-day plan year benefit; 60 days lifetime ***Out-of-Network:*** 50%* covered up to a $300 per day maximum ($150 per day paid benefit); 30-day plan year benefit; 60 days lifetime	***In-Network:*** 80%* up to $15,000 per plan year for all inpatient care ***Out-of-Network:*** You pay $500 per confinement. Then covered at 60%* up to $300 per day ($180 paid maximum per day) $15,000 per plan year maximum for all inpatient care	***In-Network:*** 90%* up to $15,000 per plan year for all inpatient care ***Out-of-Network:*** You pay $200 per confinement. Then covered at 70%* up to $300 per day ($210 paid maximum per day) $15,000 per plan year maximum for all inpatient care	***In-Network:*** You pay $200 per confinement. Then covered at 80%* up to $15,000 per plan year for all inpatient care ***Out-of-Network:*** You pay $500 per confinement. Then covered at 60%* up to $300 per day ($180 paid maximum per day) $15,000 per plan year maximum for all inpatient care	Covered in full for unlimited days; members must access PacifiCare Behavioral Health Network. (Substance abuse subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined)	Covered at 80% after $250 copay per admission for mental health. Substance abuse covered at 100% subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined. Members must access PacifiCare Behavioral Health Network

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Comparison of Medical Plan Benefits For Retirees Under Age 65 and Not Eligible for Medicare (cont.)

	Long Beach Choice POS & Great-West Life POS	Great-West PPO Value Plan	Great-West PPO High Plan	Great-West PPO Low Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only* **	PacifiCare of California Low Plan *PCP/PMG Approved Care Only* **
Outpatient Mental Health & Substance Abuse Benefits	***In-Network:*** You pay $15 per visit, then coverage at 100%, 20 visits per plan year maximum benefit for all outpatient care **Self-Referral Restriction:** You can only self refer to an Associated Therapists provider to receive in-network benefits. See your handbook for details. ***Out-of-Network:*** 50%*; 20 visits per plan year maximum benefit for all outpatient care	***In-Network:*** You pay $20 per visit. Then psychologists are covered at 100%; psychiatrists are covered up to $75 per visit. $1,500 plan year maximum for all outpatient care. ***Out-of-Network:*** 60%* covered up to $75 per visit ($45 paid). $1,500 plan year maximum for all outpatient care	***In-Network:*** You pay $20 per visit. Then psychologists are covered at 100%; psychiatrists are covered up to $75 per visit. $2,000 plan year maximum for all outpatient care. ***Out-of-Network:*** 70%* covered up to $75 per visit. $2,000 plan year maximum or all outpatient care.	***In-Network:*** You pay $25 per visit. Then psychologists are covered at 100%; psychiatrists are covered up to $75 per visit. $1,500 plan year maximum for all outpatient care. ***Out-of-Network:*** 60%* covered up to $75 per visit ($45 paid). $1,500 plan year maximum for all outpatient care	Covered in full after $10 copayment per visit for mental health; unlimited visits. Covered at 100% for substance abuse; subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined. Members must access PacifiCare Behavioral Health Network	Covered in full after $20 copayment per visit for mental health; unlimited visits for SMI; limited to 30 visits per year for all other outpatient mental health benefits. Covered at 100% for substance abuse; subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined. Members must access PacifiCare Behavioral Health Network
Lifetime Maximum Benefit for Mental Health Treatment	***In-Network:*** 60-day maximum for all inpatient care ***Out-of-Network:*** Same as In-Network	***In-Network:*** $50,000 for all inpatient & outpatient care ***Out-of-Network:*** Same as In-Network	***In-Network:*** $50,000 for all inpatient & outpatient care ***Out-of-Network:*** Same as In-Network	***In-Network:*** $50,000 for all inpatient & outpatient care ***Out-of-Network:*** Same as In-Network	Unlimited, except as noted above for substance abuse	Unlimited, except as noted above for substance abuse
Skilled Nursing Facilities (SNF)	***In-Network:*** 100% Limited to 90 days per plan year ***Out-of-Network:*** 50%* Limited to 90 days per plan year	***In-Network:*** 80%* Limited to 90 days per plan year ***Out-of-Network:*** 60%* up to $90 per day Limited to 90 days per plan year	***In-Network:*** 90%* Limited to 90 days per plan year ***Out-of-Network:*** 70%* up to $105 per day Limited to 90 days per plan year	***In-Network:*** 80%* Limited to 90 days per plan year ***Out-of-Network:*** 60%* up to $90 per day Limited to 90 days per plan year	Covered in full up to 100 consecutive days from first treatment per disability	Covered at 80% up to 100 consecutive days from first treatment per disability
Home Health	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** 50%*	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** Same as In-Network	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** Same as In-Network	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** Same as In-Network	Covered in full	Covered in full
Hospice Care	***In-Network:*** 100% ***Out-of-Network:*** 50%* (some limits apply)	***In-Network:*** 100% ***Out-of-Network:*** 100%	***In-Network:*** 100% ***Out-of-Network:*** 100%	***In-Network:*** 100% ***Out-of-Network:*** 100%	Covered in full up to 180 days per lifetime	Covered in full up to 180 days per lifetime

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Comparison of Medical Plan Benefits For Retirees Age 65 or Over and Those Eligible for Medicare (Including Those Disabled)

This table summarizes benefits for each of the City's medical plans available to retirees age 65 or older. Plan year deductibles and/or copayments are the amount you pay each year (where applicable) before your plan begins paying benefits.

	Great-West Life Medicare Supplement Plan	PacifiCare Secure Horizons (Medicare Risk Plan)	PacifiCare High Option (Medicare Coordinated HMO)	PacifiCare Low Option (Medicare Coordinated HMO)
Plan Year Deductible	***In-Network:*** $50 ***Out-of-Network:*** $50	No deductible	No deductible	No deductible
Lifetime Maximum	***In-Network:*** Unlimited ***Out-of-Network:*** Unlimited	Unlimited	Unlimited	Unlimited
Hospitalization	***In-Network:*** Days 1-60: Medicare deductible paid at 100% Days 61-90: All Covered Expenses not payable by Medicare will be paid at 100% Days 91-100: All Covered Expenses not payable by Medicare will be paid at 100% Days 101+: No Coverage Days ***Out-of-Network:*** Days 1-60: Medicare deductible paid at 100% Days 61-90: Medicare deductible paid at 100% Days 91-100: Plan pays the usual charges for semi-private room services for the hospital concerned Days 101+: No Coverage	Semi-private room covered in full for unlimited days	Semi-private room or ICU with ancillary services covered in full for unlimited days (includes benefits for specified Severe Mental Illness (SMI) as mandated by AB88)	Semi-private room or ICU with ancillary services covered at 80% after $250 copay per admission for unlimited days (includes benefits for specified Severe Mental Illness (SMI) as mandated by AB88)
Hospital Preadmission Tests	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full	Covered in full	Covered in full
Inpatient & Outpatient Surgery	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full	Covered in full	Covered in full

Comparison of Medical Plan Benefits For Retirees Age 65 or Over and Those Eligible for Medicare (Including Those Disabled) (cont.)

	Great-West Life Medicare Supplement Plan	PacifiCare Secure Horizons (Medicare Risk Plan)	PacifiCare High Option (Medicare Coordinated HMO)	PacifiCare Low Option (Medicare Coordinated HMO)
Physician Charges for Hospital Care & Surgery	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full	Covered in full	Covered in full
Emergency Room	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	$20 copay per visit. Waived if admitted to the hospital.	$50 copay per visit. Waived if admitted to the hospital.	$50 copay per visit. Waived if admitted to the hospital.
Physician Office Visits	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full	$10 copay per visit	$20 copay per visit
Outpatient X-ray & Laboratory	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full	Covered in full	Covered in full
Maternity Care	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full. Complete maternity care includes all care before, during and after birth (up to 6 weeks post-partum). Includes all medically indicated diagnostic testing and reasonable and necessary services associated with pregnancy	Covered in full except for certain elective procedures which are subject to various copays	Covered in full for outpatient visits; covered at 80% after $250 copay per admission for hospitalization. Certain elective procedures subject to various copays.
Routine Physical	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	Covered in full	Covered in full after $10 copay. Limited to one exam each calendar year	$20 copay for periodic exam if determined medically necessary by PMG
Well-Baby Care	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	Not covered	Covered in full (for children under 2)	Covered in full (for children under 2)

Comparison of Medical Plan Benefits For Retirees Age 65 or Over and Those Eligible for Medicare (Including Those Disabled) (cont.)

	Great-West Life Medicare Supplement Plan	PacifiCare Secure Horizons (Medicare Risk Plan)	PacifiCare High Option (Medicare Coordinated HMO)	PacifiCare Low Option (Medicare Coordinated HMO)
Prescription Drugs	***In-Network:*** When you use a PCS pharmacy: $5 generic; $15 brand. Mail order services available. Subject to $2,000 paid maximum benefit per calendar year. ***Out-of-Network:*** When you use a non-PCS pharmacy, you must file a claim form directly with PCS; the benefit amount paid will be reduced; subject to $2,000 paid maximum benefit per calendar year.	$5 generic; $5 brand; 30-day supply. Mail order services available at 2 times the regular copay for 90-day supply; formulary applies.	$5 generic, $15 brand; $25 non-formulary; 30-day supply Mail order services available at 2 times the regular copay for 90-day supply Non-formulary means prescription drugs that are not on the approved drug list (formulary).	$5 generic, $15 brand; $25 non-formulary; 30-day supply Mail order services available at 2 times the regular copay for 90-day supply Non-formulary means prescription drugs that are not on the approved drug list (formulary).
Chiropractic Care	***In-Network:*** Plan pays 100% of all covered expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	You can self refer for a $5 copay per visit up to 20 visits per year	$10 copayment; 40 visits (combined with acupuncture) per year through ASHP provider	$15 copay, 20 visits per year through ASHP provider
Acupuncture	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	Not covered	$10 copayment; 40 visits (combined with chiropractic) per year through ASHP provider	Not covered
Durable Medical Equipment (DME)	***In-Network:*** All covered expenses not payable by Medicare will be paid up to 100% if rented or purchased from a contracted facility ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full	Covered in full	Covered in full
Hearing Aids	***In-Network:*** Covered at 80% after the calendar year deductible. Benefit paid maximum of $1,000 every 3 years ***Out-of-Network:*** Same as In-Network	Not covered (35% discount applies at limited network facilities)	100%; limit of one for each ear in a 3-year period** (hearing exam covered in full after $10 copay)	Not covered (hearing examinations covered after a $20 copayment)
Orthotics	***In-Network:*** Covered at 80% after the calendar year deductible. Benefit paid maximum of $75 every 3 years ***Out-of-Network:*** Same as In-Network	Therapeutic shoes and supportive devices for feet are covered only for those with diabetic foot disease.	Not covered	Not covered
Vision Benefits	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	Eye exam covered in full at Participating Medical Group. Lenses covered in full if network provider used; $75 frame allowance every 2 years; covered through Vision Service Plan (VSP).	Eye exam covered in full once every 12 months at contracted MES facility. Lenses covered in full if network provider used; $60 frame allowance every 2 years; Covered through Medical Eye Services (MES) .	Eye exam covered in full once every 12 months at contracted MES facility. Lenses covered in full if network provider used; $60 frame allowance every 2 years; Covered through Medical Eye Services (MES).

Comparison of Medical Plan Benefits For Retirees Age 65 or Over and Those Eligible for Medicare (Including Those Disabled) (cont.)

	Great-West Life Medicare Supplement Plan	PacifiCare Secure Horizons (Medicare Risk Plan)	PacifiCare High Option (Medicare Coordinated HMO)	PacifiCare Low Option (Medicare Coordinated HMO)
Inpatient Mental Health Treatment	***In-Network:*** Plan pays 100% of all Medicare eligible expenses not payable by Medicare for a confinement at a Medicare-participating hospital ***Out-of-Network:*** Plan pays the Medicare deductible and any applicable coinsurance for a confinement at a Medicare-participating hospital	Limited to a lifetime limit of 190 days in a Medicare-participating psychiatric hospital	Covered in full. Unlimited days; members must access PacifiCare Behavioral Health Network	Covered in full. Unlimited days; members must access PacifiCare Behavioral Health Network
Outpatient Mental Health Benefits	***In-Network:*** Plan pays 100% of the eligible charges for the service, subject to a $250 calendar year maximum ***Out-of-Network:*** Plan pays 50% of Medicare Allowable Expenses (Medicare pays the other 50%) subject to a $250 calendar year maximum	$10 copay per visit; unlimited visits	Covered in full after $10 copay per visit. Unlimited visits; members must access PacifiCare Behavioral Health Network	Covered in full after $20 copay per visit. Unlimited visits; members must access PacifiCare Behavioral Health Network
Inpatient Substance Abuse Treatment	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	Covered in full	Covered at 100%; $25,000 annual maximum and $35,000 lifetime maximum, combined with outpatient; members must access PacifiCare Behavioral Health Network	Covered at 100%; $25,000 annual maximum and $35,000 lifetime maximum, combined with outpatient; members must access PacifiCare Behavioral Health Network
Outpatient Substance Abuse Treatment	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	$10 copay per visit	Covered at 100%; $25,000 annual maximum and $35,000 lifetime maximum, combined with inpatient; members must access PacifiCare Behavioral Health Network	Covered at 100%; $25,000 annual maximum and $35,000 lifetime maximum combined with inpatient; members must access PacifiCare Behavioral Health Network
Skilled Nursing Facilities (SNF)	***In-Network:*** Plan pays 100% of all covered expenses not payable by Medicare up to the plan limit of 100 days ***Out-of-Network:*** Plan pays the daily coinsurance not payable by Medicare up to the Medicare Allowable Expense Limit. No plan benefit is payable after the 100th day	Covered in full for 100 days per benefit period	Covered in full up to 100 consecutive days from first treatment per disability	Covered in full up to 100 consecutive days from first treatment per disability
Home Health Care	***In-Network:*** Expenses for private duty nursing by an RN will be paid at 80% up to lifetime maximum of $5,000 after $50 calendar year deductible ***Out-of-Network:*** Same as In-Network	Covered in full with no limit on number of visits when approved by PCP	Covered in full	Covered in full
Hospice Care	***In-Network:*** Plan pays 100% of all covered expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare copayments up to the Medicare Allowable Expense Limit	Covered in full if elected by member and determined medically necessary by PMG	Covered in full up to 180 days per lifetime	Covered in full up to 180 days per lifetime

Comparison of Medical Plan Benefits For Retirees Age 65 or Over and Those Eligible for Medicare (Including Those Disabled) (cont.)

	Great-West Life Medicare Supplement Plan	PacifiCare Secure Horizons (Medicare Risk Plan)	PacifiCare High Option (Medicare Coordinated HMO)	PacifiCare Low Option (Medicare Coordinated HMO)
Dental Care	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	You pay $5 for each office visit up to 4 visits per year. You pay $0 for additional visits per year. You pay $15 for teeth cleaning; $10 for prescribed routine x-rays. You must use network providers. Some limits apply. See benefit book for details.	Not covered	Not covered

Notice to Participants

New Federal laws impose certain requirements on group health plans. Under these new Federal laws, collectively referred to as HIPAA, a group health plan is limited in imposing pre-existing conditions; must offer employees and dependents the opportunity to enroll in the plan outside of open enrollment periods in certain situations; cannot discriminate on the basis of health status with respect to eligibility for plan participation and premium costs; cannot impose discriminatory lifetime or annual benefit limitations for participants with mental illness; and must permit hospital admissions (if otherwise covered by the plan) of at least 24 hours in the case of normal deliveries and 48 hours in the case of Cesarean Sections.

With respect to many of the above restrictions, the City of Long Beach is currently in compliance with State law requirements and many of the HIPAA requirements under Federal law. Further, the City of Long Beach does not discriminate on the basis of health status with respect to eligibility for health plan participation or premium costs.

As part of the new Federal law, plan sponsors of non-Federal government plans can elect to be exempt from the above-mentioned requirements. The City of Long Beach has elected exemption from HIPAA requirements for the plan year beginning December 1, 2002 and ending the following November 30, 2003.

Special Assistance

This Retiree Benefits Summary information is available in an alternate format by request to the Department of Human Resources and Affirmative Action. If you need any special assistance or special materials to clearly and fully understand all of your benefit options, please call (562)570-6621. We would be more than happy to assist you in any way we can.

Special Notice

This Benefits Summary reviews health and dental benefits for the City of Long Beach, but it is not a contract. Full details about the benefits are provided in legal plan documents and insurance contracts that govern the program. If there are differences between this Benefits Summary and those documents and contracts, the legal documents will control.

The actual plan documents may be inspected upon written request to the Employee Benefits & Services Officer at least 10 days prior to review. A copy of the entire plan document(s) may be obtained in the same manner for a 25-cent per page copying charge.